Risk Assessment

Suicide:	✓ None	✓ Idea	__ Plan	__ Means	✓ Prior Attempt
Homicide:	✓ None	__ Idea	__ Plan	__ Means	__ Prior Attempt

Comments: (If yes to any of the above, describe and assess the following seriousness of intent, identified risks to client or potential victim, suicide attempts: method, number of attempts, approximate dates, action take: referrals, e.g. hospitalizations, psych eval., etc....)

"SELF-INFLICTED PAIN THAT MAKE ME FEEL LIKE A MAN. I LOVE IT, MAKE ME FEEL LIKE A MAN."

AGE 14 & 15 - 2 ATTEMPTS, CT STATED WHEN HE CRACK HE BECAME IRRATIONAL

CT DENIED ANY CURRENT INTENT OR PLAN

History of Abuse

Childhood: __ None __ Physical X Sexual __ Emotional If reported, date:_____ Legal Disposition_____

Adult: X None __ Partner Abuse/Battering __ Emotional __ Family violence __ Stalking __Rape

Comments: (If yes to any of the above, describe and assess the current risk to client) CT STATED HE WAS SEXUALLY ABUSED BY SCHOOL COUNSELOR WHO WAS ALSO A POLICEMAN. NEVER REPORTED IT BECAUSE INCIDENT THINK MYSELF WOULD BELIEVE HIM.

Client Strengths: PERSONALITY, MOTIVATION

Client Limitations to TX: DRUG USE

Special Needs and Arrangements: (Any accommodations necessary?) _____

Diagnostic Formulation

(behavioral support for diagnosis): CT PRESENTS W/ DEPRESSED MOOD, ANXIETY, SUICIDAL IDEATION W/ PAST CURRENT PLAN OR INTENT, HYPERSOMNIA, LOW ENERGY LEVELS, FATIGUE. CT ALSO REPORT FEELING OF PANIC WHEN IN CROWDS OF PEOPLE FEELING THAT SOMEONE IS GOING TO HURT HIM AND PEOPLE ARE STARING AT HIM.

(diagnoses to be ruled out): HYPERSOMNIA RELATED TO MAJOR DEPRESSIVE DISORDER, BORDERLINE PERSONALITY DISORDER PANIC DISORDER W/ AGORAPHOBIA, BIPOLAR DISORDER

(clinical assessment of data and analysis which is integrated to identify strengths and prioritize needs, which may include health safety and inclusion): CT IS A SINGLE, UNEMPLOYED, 28 YR/OLD MALE WHO PRESENTS WITH DEPRESSED MOOD, FATIGUE AND REPORTS HYPERSOMNIA: SLEEPS 15+ HRS/A DAY. CT REPORTS FEELING OF FATIGUE MAKE IT DIFFICULT TO HOLD A JOB, CT REPORTS SEVERAL TERMINATIONS FOR SLEEPING ON THE JOB. CT REPORTED USING AMPHETAMINES TO MAINTAIN ALERTNESS DURING LAST JOB. CT HAS LONG HX OF SUBSTANCE ABUSE INCLUDING MARIJUANA, ECSTASY, MUSHROOMS, AND CRACK/COCAINE. CT WAS MARRIED AND DIVORCED IN LESS THAN 90 DAYS CALLS HIS EX-WIFE A "PSYCHOPATHIC BITCH", CT WAS SEXUALLY ABUSED BY A SCHOOL COUNSELOR WHO ALSO WORKED AS A POLICE OFFICER. THIS WENT UNREPORTED BECAUSE CT FEARED NO ONE WOULD BELIEVE HIM. CT STATES BELIEF THAT THIS ABUSE IS THE CAUSE OF ANXIETY CT FEELS IN GROUPS. CT SAID LITTLE ABOUT FAMILY SAYING THAT IT MADE HIM ANGRY TO TALK ABOUT PEOPLE (HIS BROTHERS) DOING BETTER THAN HE IS.

[X] Appropriate for Admission to TGC ADP program.

[ ] Not Appropriate for Admission; Second Opinion Options and referral(s) given to: _____

DSM IV Diagnosis:

Axis I. Major Depressive Disorder, Recurrent, Moderate — **Code:** 296.32
Mood/Alcohol Abuse — **Code:** 305.80
Amphetamine Abuse — **Code:** 305.70

Axis II. Deferred — **Code:** 799.9

Code:

Axis III. None — **Code:** 100

Code:

Axis IV. Primary Support, Social Environment, Educational, Occupational — **Code:** 01, 02, 03, 04

Code:

Axis V. (GAF) 49

Preliminary Treatment Plan

(For CMH clients, if Case Management Services are indicated, add to Preliminary Tx Plan)

Goal #1: Stabilize Mood

Objective (Client will)

a. Identify Triggers to Mood Swings

b. Begin to increase ability to cope w/ triggers to mood

c. Make & keep psychiatric evaluation appt & comply w/ tx.

d. Coordination of care needed with: [ ] Primary Care Physician [ ] School [ ] Other

e. Arrange to contact Servicia & consider enrollment in IOP programming

Goal #2:

Objective (Client will)

a.

b.

c.

Frequency of contacts: (during first 30 days) [X] Weekly [ ] Bi-weekly [ ] Monthly [ ] Other(explain)

Clinician's Signature/Credentials — Date: 4/22/04

Supervisor's Signature/Cred. — Date: 4-22-04

Psychiatric recommendations:

[X] Referral for a physical examination is recommended [ ] A physical examination is not required at this time.

Psychiatric Certification of Admission: I concur with the provisional diagnosis and initial treatment plan and have made recommendations as appropriate.

Psychiatrist's Signature/Credential — Date: 4/22/04

Pc/rev. 11/21/02

THE GUIDANCE CENTER
DISCHARGE SUMMARY
To be completed within 15 days of termination

Client Name: David Kapuscinski **DOB:** 7/8/75 **Client ID:** 08121

Opening Date: 4/22/04 **Closing Date:** 2/9/07

Summary of presenting problem: Client presented with depressed mood, anxiety, agitation, suicidal ideation w/o intent or a plan, Client also suffered from panic attacks and social anxiety. Client reported past sexual abuse and difficulty with sleep and fatigue.

Course and progress toward treatment goals, using impact of services provided and client's response: Therapist never saw client in treatment and therefore cannot determine how client progressed in treatment.

Psychotropic Medication(s) Prescribed at Discharge with dosage: Adderall XR (15 mg), Strattera (25mg)

Reason for discharge: [X] Planned discharge [ ] Unplanned with Staff Approval

[ ] Unplanned without Staff Approval Explain circumstances with unplanned: Client non-compliant with treatment, not attending psychiatrist, and/or returning phone messages.

Final Diagnosis: (Unabbreviated narrative)

Axis I:	Major Depressive Disorder	Code:	296.32
	Marijuana Abuse Amphetamine Abuse	Code:	305.20 305.70
Axis II:	Diagnosis deferred	Code:	799.99
	Diagnosis deferred	Code:	799.99
Axis III:	None	Code:	100
	None	Code:	100
Axis IV:	Primary support, social environment,	Code:	01, 02, 03,
	educational, occupational	Code:	04
Axis V:	GAF 49		

Clinician rating of client functioning at time of discharge:

Rating	Area
2	Job/school functioning
2	Home responsibilities, if applicable
2	Relationship with spouse, if applicable
1	Relationship with family, if applicable
2	Physical functioning
2	Psychological functioning
2	Acceptance of alcohol-drug dependence
2	Coping abilities
2	Overall functioning
4	Prognosis

1 = poor
2 = fair
3 = good
4 = not applicable

Aftercare Plan/Recommendations to Client at Discharge: Continue to seek treatment in future.

[illegible], MS, TLLP
Therapist's Signature/Credentials
Date 2/9/07

[illegible]
Supervisor's Signature/Credentials
Date 2/10/07

[illegible] MD
Psychiatrist's Signature/Credentials
Date 2/19/07

Discharge Summary/pc/09/04

THE GUIDANCE CENTER
Strengthening families. Changing lives.

Comprehensive Biopsychosocial Assessment

Date of Assessmen
10/1/2008

Client Name: KAPUSCINSKI,DAVID **Client ID:** 8121 **Date of Birth:** 7/8/1975

Client Info

Family Name: Kapuscinski, David
Marital Status: SINGLE
Sex: Male
Race: WHITE/CAUCASIAN
Employment Status: Employed Part Time (<30 hours/week)
Program Intake Type: Adult

Presenting Problem / Chief Complaint

Presenting problem / Chief Complaint: David is a 34 year old single male of who identifies his ethnicity as "White." CC is as follows: "to go back on my meds."

History

History: Client reported the following: "I was on Adderral for ADHD. I was taking 0.5 Xanax for anxiety. I don't take it every day. I've had panic attacks for about 8 or 9 years. I have a nerve condition. I go sometimes a week and I'm fine. It gets hard to breath feels like everything is going to close in on me. When I'm in tight spaces I panic. When in a crowded area I can't believe. I can't focus. I start like 10 different things and they don't get finish. I get bored w/ the tasks. I couldn't hold a job until I went on the Adderall. W/ out it the Adderall I'm unorganized and messy. I had depression a long time ago b/c I had someone who use to verbally abuse me. But I'm fine now. I get down. I want to give up. I get so frustrated w/ things and if I don't complete something the way I want or intended to I get down. I feel like I'm a failure if I can't do something. I feel like an idiot. I have to smoke cigarettes to keep my composure. I get irate and curse. I have a bad temper. I use to break glasses over my head. I had to go to the hospital 5 months ago b/c I hit myself w/ glass. I have anger issues. I came here about 2 years ago. (Avatar reports AOP services from 4/22/04 to 2/9/07). I moved out of the city and didn't have a way here. When here, I got counseling and got to vent. I got a better way of life. My family doctor was prescribing me the Adderall but he just retired. I've had 3 hospitalizations but I can't remember them all."

Developmental History

Communication Style: English

Hospitalization

Is there a hospitalization history?: Yes
Date of Hospitalization: "11/8/2009"
Name of Hospital: Wyandotte
Reason: "anger issues"

Hospitalization

Is there a hospitalization history?: Yes
Date of Hospitalization: per chart 4/14/04
Name of Hospital: Kingswood
Reason: per chart, suicidal/ drugs

Substance Use / Abuse

Is there a substance use / abuse history?: Yes
Name of Drug: Alcohol
Age at Time of First Use: 16
Age the Use First Became a Problem: 0
Quantity: "12 beers"
Frequency: "alot"
Date of Last Use: 1/1/10

Patterns of Use: Client reported: "when stressed out in relationship"

Continued Substance Use Despite Negative Consequences: Yes
Previous Substance Abuse Treatment: No
Treatment Type:
Treatment Outcome:
Explain Treatment Outcome:

Participation in Self Help Groups?:Yes
Client's Perception of Experience:Client reported:"I went to NA. Half the people there are full of shit which doesn't do much for me. I tried AA and I'm not going to watch a whole buch of people stoned out of their mines."

Problems Associated with Substance Use: Physical Health, Relationships
Explain Problems: Client reported: "there was a lot of violence. I broke glass over my head, got into fights."

Family History
Is There Family Psychiatric or Substance Abuse History?: Yes
Explain Family MI and SA History: Client reported "my dad use to drink alcohol and my brother drinks a lot."

Education/Vocation
Has Reason Education Not Completed: "Didn't like school."
Special Education: Yes
Desire for Future Education Opportunities?: Yes
Area of Preference of Study: GED
Prognosis for Employment: Good
Educational / Vocational Needs and Appropriateness: Client reports that he is currently employed in the valet department via Wyandotte Hospital earning $7 hourly at 30 hours weekly. Client reported that he has always wanted to complete his GED.

Availability of Educational Programs: Undisclosed
Referral for Educational Needs: Yes
Income Source: SDA,SSI,SSDI
Is client earning minimum wage?: Yes
Referral for vocational Needs: No

Employment Status: Part-time
Reason Unemployed: N/A

Biomedical Dimension
Medical / Physical: Under the care of primary care physician
Any concerns with Sexuality?:
Explain Concerns:
Comments: No concerns regarding sexual functioning reported by client despite his report of mood instability.

Physical Assistance:
Vision: No problems
Hearing: No problems
Other Physical / Medical Characteristics: Moderate assistance
Challenging Behavior: Moderate assistance
Conditions being treated / untreated: Client reported: "Asthma, arthritis, fractures and breaks from accident auto 2 years ago."

Barriers to treatment: Lack of awareness, Transportation

Assistance Needed For
Mobility:Yes
Independence:Yes
Medication Administration:Yes
Personal:Yes
Household:No
Community:Yes
Medication Allergy: Yes
Indicate Drug: Kleeflex, Penicillin, Erythromycin
Referral for Medical Care Needs: Yes

Pain Assessment

Does Client Report Chronic Pain:Yes
Where Is Pain Located:"arthritis in joints"
How Long:"2 years"
Is Client Being Treated:Yes
Referral for Pain Management:Yes

Nutritional Assessment

If response in 3 or more areas indicated possible nutritional problems, or diabetic condition is not under control, a referral to case management for further nutritional referral is needed.

Current Appetite: Good
Unplanned Weight Loss / Gain in Past Six Months: No Change
Amount Gained / Lost:
Number of Nutritious Meals Eaten Per Day: "3 or more"
Diabetic: No
Following ADA recommended Diabetic Diet:
Blood Sugar Within Acceptable Range:
Eating disorder: Not Applicable
Explain: Denied

Nutritional Referral: No

Mental Status Assessment

Appearance: Well Groomed
Other:

Speech: Normal
Other:

Motor Activity: Calm
Other:

Inter-Personal: Cooperative, Other
Other: Covertly aggressive

Orientation: Person, Place, Time
Memory:
Type of Impairment:
Judgement:
Type of Impairment:
Insight:
Level of Impairment:
Intelligence:
Attention:
Thought Processes:
Abnormal Thought Processes:
Hallucinations:
Type of Hallucinations:
Affect:
Notable Affect:
Mood:
Notable Mood:
Mental Status Comments:

Recovery Environmental Dimension

Legal Issues: No
Correction Status: Awaiting trail
Explain Legal Issues:

Describe the Relationship Between Presenting condition and Legal Involvement: N/A

Describe how the client's legal situation will influence the client's treatment progress: N/A

Spiritual Assessmet (Values and Beliefs, and their potential impact): No values / beliefs ID that could have impact on recovery / treatment.

Meaningful Activity / Community Involvement / Inclusion: Other, Part Time Work

Other:co parenting
How does the above activity or lack of activity impact client's condition:Client reported: "I need a car. I'm just not motivated to do anything period. My energy is down. I can't focus on anything I haven't been interested in anything lately."

Natural Supports

Nature of Support: Family/Friends no assistance
Explain Nature of Family/Friend Involvement/Support: Client reported that he cannot talk to anyone about his problems and relies on himself for support.

Existing support system at risk?: No, caregiver involved
Family enrolled / receiving wraparound services?: No
Child enrolled in Early-On?: No
Child enrolled in Head Start?: No
Family Circumstances: Client reported: "I get along w/ my parents good now that I don't live w/ them. When we stayed together it was fights constantly. My dad tries to compete w/ me and my brothers and he thinks hes 16. I get along w/ my brothers good. I'm the baby of the family. My brothers stick up for me. I think my dad hates me personally. My brothers use to think that I was a problem. My mom loves my girlfriend. So does my brother. This is the straightest I've ever been since I've been w/ this girl. When I'm down and out my dad likes it b/c he likes to control me. I'm closest to my mother. I've been in this relationship for a year. I help to take care of my girlfriend's daughter."

Risk Assessment

Type of Risk:
Current Risk:
Ideation:
Plan:
Means:
Prior Attempt(s):
Seriousness of Intent:
Identified Risks to Client or Potential Victim:
Number of Attempts:
Method:
Approximate Dates:

Clinician's Response to Risk

Clinician's Response to Risk: Client denied hx of suicidal / homicidal ideation / attempts. He reported that he has hit himself in the head w/ glass. He declined to complete a safety plan explaining, "I'm not suicidal or homicidal. I want to live. Thats not the problem."

History of Adult / Child Abuse
Whether abuse occurred?: Yes
Child / Adult: Child
Was it Reported: Yes
DHS ABuse and Neglect Involvement: Yes
Explain: Client reported the following: "My dad use to kick the shit out of me. I told the counselor at school. Social services showed less than an hour later and my dad said unless you are going to clothe, housed and feed the boy you can't tell me what to do w/ him. Charges were never filed. He use to get drunk all the time and beat the shit out of me."
DHS Other Program Involvement: No
Legal Disposition:
Type of Abuse: Family Violence
Exploitation:
Time Frame:
Assess Current Risk to the Client: Client denied current risk at harm.

History of Adult / Child Abuse
Whether abuse occurred?: Yes
Child / Adult: Adult
Was it Reported: No
DHS ABuse and Neglect Involvement: No
Explain:
DHS Other Program Involvement: No
Legal Disposition:
Type of Abuse: Emotional
Exploitation: No
Time Frame:
Assess Current Risk to the Client: Client reported that his father remains emotionally abusive towards him. He denided current risk at harm.

Safety Assessment
Safety Concerns: Yes
Explain Concerns: Home
Immediate Measures Taken or Needed: Client denied issues w/ safety and declined to complete a safety plan.

If safety concerns have been identified, a safety Plan MUST be completed:
Safety Plan: This writer encouraged client to seek counseling, to participate in anger management groups, to continue medication reviews, to continue to use strategies which he verbalizes that he currently uses to suppress anger arousal, to get invovled in prosocial and constructive activities and to contact CRISIS if he is feeling explosive.

Diagnostic Formulation:
Safety Concerns: lient reported history of physical and emotional abuse as a child by his father. He reported history of receiving special education. He reported that as a child he was diagnosed with ADHD. He explained that as an adult he began using alcohol to deal with stressors in his romantic relationship. He reported that in such relationship he was also emotionally abused. Client reported he developed panic attacks as well as depression. He reported that he is easily frustrated. He reported that he has difficulty focusing and completing tasks. He stated that he has required psychiatric inpatient care at least 3 times to deal with mood instability. Client reported that out of his frustration he has broken glass over his head requiring medical attention. Client reported that he has disturbance in sleep, lack of motivation and no interest in engaging in meaningful and / or constructive activities. Client reported that his treatment w/ psychotropic medications has help to stabilize many of his reported symptoms.

Axis I. MAJOR DEPRESSIVE DISORDER, RECURRENT UNSPEC	**Code:** 296.30
Axis I.ALCOHOL ABUSE	**Code:** 305.00
Axis I.ANXIETY DISORDER NOS	**Code:** 300.00
Axis II.DIAGNOSIS DEFERRED ON AXIS II, DIAGNOSIS OR CON	**Code:**799.9
Axis III.ASTHMA, UNSPECIFIED, WITHOUT MENTION OF STATL	**Code:**493.90
Axis III.PAIN IN JOINT, MULTIPLE SITES	**Code:**719.49
Axis IV. Primary Support Group	**Code:**Yes
Axis IV. Social Enviroment	**Code:**Yes
Axis IV. Education	**Code:**Yes
Axis IV. Occupational	**Code:**No
Axis IV. Housing	**Code:**No

Axis IV. Economic **Code:**No
Axis IV. Health Care Services **Code:**No
Axis IV. Legal System / Crime **Code:**No
Axis IV. Other Problems **Code:**Yes
Axis V Current GAF Rating: (50) 41 - 50 Serious Symptoms Or Impairment
GAF Highest Last 12 Months: (50) 41 - 50 Serious Symptoms Or Impairment
GAF Lowest Last 12 Months: (41) 41 - 50 Serious Symptoms Or Impairment

Multidimensional Assessment

Dimension 1 Acute intoxication and / or withdrawal potential (refer to presenting problem and substance abuse history, safety assessment): Moderate
Barriers: Client reported that he has consumed alcohol in the last 2 weeks.

Dimension 2 Biomedical conditions and complications (include medical/physical conditions, and nutritional issues, and safety assessment): Moderate
Barriers: Client reported experience of pain from complications of an auto accident which he was involved in approximately 2 years ago. Client reported sleep disturbance.

Dimension 3 Emotional/behavioral/cognitive conditions and complications (refer to psychiatric history and treatment compliance, mental status, risk assessment)
Mental Health Risk:Moderate
Substance Abuse Risk:Moderate
Barriers:Initially client reported that symptoms of depression were stable and were of consequence from previous relationship. Once relationship was terminated client stated that he no longer felt depressed. Client reported that he continues to struggle w/ symptoms of ADHD and anxiety. Client denied having problems w/ alcohol and felt that his consumption of is not a problem. He later reported that he engaged in self harming behavior while under the influence. He denied use of other substances as well as hx of suicidal ideation / attempts. However, information found in existing chart contradicts this.

Dimension 4 Readiness to change(refer to MI and SA treatment history and compliance
Mental Health Stage: Preparation
Substance Abuse Stage: Pre-contemplation
Motivational Barriers: Client seems to be in denial regarding MI and SA.

Dimension 5 Relapse/continued use problem (refer to history of abuse, meaningful activities, community involvement/inclusion, natural support)
Mental Health Risk: Moderate
Substance Abuse Risk: Moderate
Barriers: Client denied current prosocial involvements and / or engagment in meaningful activities.

Dimension 6 Recovery environment (refer to substance abuse and treatment history, legal, spiritual and self help participation/acceptance and safety issues, meaningful activities/communiy involvement / inclusion and natural supports, effects on family)
Mental Health Risk:Moderate
Substance Abuse Risk:Moderate
Stage:Preparation
Barriers:Client denied having a support system. He is not currently participating in supported recovery.

Preliminary Treatment Plan

Goal #1: Improve emotional stability and live Substance free lifestyle.

Objectives 1: Reconsider development of safety plan

Objectives 2: Reconsider participation in individual therapy

Objectives 3: Complete psychiatric evaluation

Referral for the client(either internal or external) indicate referral exlored and if they were accepted or rejected: Client declined participation in individual therapy and to develop a safety plan; however, he accepted referrals to case management and psychiatric evaluation.

Other referrals for the family (either internal or external) indicate referral explored and if they were accepted or rejected:
N/A

Case Management Needed: Yes
Need in the following areas: Family, parenting, supported recovery, social, transportation, medical, pain management

Tracie Cozart-Bosley, LMSW

COZART-BOSLEY,TRACIE MSW LMSW

1/11/10

~~10/7/2008~~

Supervisor Signature

1-11-10

Date Signed

Psychiatric recommendations:

[X] Referral for a physical examination is recommended Psychiatric Certificatin of Admission: I concur with the provisional diagnosis and initial treatment plan and have made recommendations as appropriate.

MD

01/12/10

Psychiatrist's Signature/Credential

Date Signed

Final